



JACKSON COUNTY INTERMEDIATE SCHOOL DISTRICT  
EMERGENCY INFORMATION & MEDICAL TREATMENT RELEASE FORM

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Student's Address \_\_\_\_\_ Home Telephone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ (Home & cell numbers will be used for Global Connect Calling System)

	Name	Address (If different than student)	Employer & Telephone #	Cell #	Email address
Mother					
Father					
Guardian					
Group Home & Manager					

SPECIAL PHYSICAL CONCERNS

Student's Medications (Include Medications given at Home)

Name of Medication	Dose	Time(s) Given

Seizure Disorder: Yes \_\_\_ No \_\_\_ Allergies: Yes \_\_\_ No \_\_\_ Allergy to \_\_\_\_\_

Additional Health Concerns \_\_\_\_\_

Special Adaptive Devices (eyeglasses, braces, wheelchair, etc.) \_\_\_\_\_

IN CASE OF EMERGENCY & NO ONE CAN BE REACHED AT HOME, AT WORK OR BY CELL, CALL ONE OF THE FOLLOWING:

Name	Address	Telephone #	Cell #	Relationship to student
Physician:				Physician
Medical Insurance Co. –				

If an emergency arises while the above named student is participating in his/her education program, you are authorized on my behalf and on my account to take such measures and arrange for such medical and hospital treatment as you may deem advisable for the health and well-being of the student. In case of emergency, you have my permission to transport my son/daughter/ward home by special education bus or personal vehicle. In case of emergency, and the parent(s)/guardian(s) are not available, you may rely on the listed emergency contact to act in my capacity, and share such information as is necessary in the circumstance with the emergency contact, until such time as I am available.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only:

Resident School District: \_\_\_\_\_  
ASD SCI SXI ECDD MOCI

Teacher: \_\_\_\_\_  
Photo/Video/Excursion/Swim/Website/Facebook/Standing Orders